MANLEY (T. H.)

Reprinted from THE BROOKLYN MEDICAL JOURNAL, February, 1891.

THE REPORT OF A CASE OF A LARGE INTERSTITIAL FIBROID OF THE UTERUS REMOVED BY ABDOMINAL SECTION, WITH SOME OBSERVATIONS IN RELATION TO THE MOST RATIONAL METHODS OF DEALING WITH NEOPLASTIC FORMATIONS WHICH ORIGINATE IN THE MUSCULAR FIBRE OF THE UTERUS.

BY THOMAS H. MANLEY, M.D.,

Visiting Surgeon to Harlem Hospital, New York.

Since Apostoli promulgated his views, in connection with the therapeutic value of electricity in the treatment of diseases and pathological conditions peculiar to the internal organs of generation, in woman, and especially, of those solid tumors of the uterus, which are fibrous-like in consistence and color, but are histologically identical with non-striped muscle, a furious war of words has raged, between those who are enthusiastic advocates of electricity and those who do not hesitate to relegate it to the almost endless host of fads which are being boldly thrust forward on the profession, by members of all grades and rank.

On one side it has been contended, that it acts with unerring certainty, in neoplastic formations of benign origin; in chronic inflammation, congestion, hæmorrhage, suppuration, and even in neuralgias and other neuropathies of the womb and its appendages.

Its most violent and uncompromising enemies go to the other extreme, and regard its application, under many circumstances, not only useless, but harmful, and claim, that beyond its psychological effect, it accomplishes no good whatever.

Up to the present time the use of electricity has been purely empirical. There certainly has been no want of theories to explain its *modus operandi;* but none of them can be accepted, until it can be demonstrated, in other parts of the body, superficially located, that it

SURGEON GEN'L'S OFFICE
426
LIBRARY

will accomplish, in pathological conditions there, what is claimed for it in the deep recesses of the female pelvis.

However, though we may not be able to explain its mode of action, yet; if it will relieve pain, conduce to bodily comfort, and make life supportable, in that class of female diseases, which have an inherent limit, and by it we may conduct our patient, beyond that line in life when atrophic changes commence, then, indeed, it must be accepted, as a therapeutic adjuvant, of infinite value.

With the case herein recorded this, the electro-therapeutic agent, was faithfully tried.

History of the Case.—The patient, Mrs. F., 39 years old; married five years. She said, that in earlier life, she was accustomed to hard work, and in one situation which she held, she was often required to carry heavy weights, which, when ascending a stairs, she would support against her left hip and groin.

Twelve years before, simultaneously she noticed two things which gave her much anxiety. There appeared a small fullness in the left iliac region, accompanied with a dull, intermittent pain, which was aggravated and intensified, at each menstrual epoch. It made a slow but steady march in growth, until at the time, I examined her, when a large growth occupied the abdominal cavity, though, extending mostly into the left side.

She said that for the past five years her general health began to fail and her bodily strength was visibly affected. She had trouble with breathing on slight exertion, and in climbing stairs. Obstinate constipation set in, and the bowels would only move when large injections were administered. She had an irritable bladder, which gave her much suffering, and required her to rise to urinate several times at night. During the past two years her tumor became an active cause of physical discomfort. When she would lie down she could obtain ease in one position only, for a short time, having to turn from side to side, unceasingly. On physical examination, no organic disease could be discovered, though she was greatly reduced in flesh.

She had been under treatment and in the hands of different physicians for many years; and as no two of her medical attendants quite agreed on the nature of her malady, diversity of treatment was the rule. Chronic inflammation of the ovary was the first diagnosis. Shortly after her marriage she was again examined, and told she had a "stray pregnancy"—that the infant was growing outside the uterus. In fact, the whole gamut of pelvic disorders, which might give rise to a localized swelling—and their name is legion—was run through. And, accordingly she was under constitutional treatment, was blistered, bandaged and poulticed at divers times.

But, nevertheless, within the past year, she came under the care of a gentleman who, regarding her growth as a fibroid tumor, tried the direct effects of electricity on it, twice a week for six months.

At first she said she thought it helped her, but in a short time after each *séance* her whole abdomen felt very tender and sore. For some time before she was referred to me, she had given up, in despair all kinds of treatment. Now realizing that something radical must be done, after long and thoughtful consideration, she decided to hazard an operation. From the original seat of the growth on the left side and the position which the intestines took, one would suspect ovarian or parovarian tumor. But a uterine examination and exploratory puncture, decided the probable nature of the enlargement.

Now, then, that we had to deal with what seemed more like a fibroid than anything else, how would we attack it and remove it without putting our patient's life in great danger? If the actual pathological condition and morbid anatomy could be positively determined beforehand in those cases—if a correct diagnosis could be made, not as to the elements of the growth alone, as that sometimes is of small consequence compared with the involvement and implication of other organs—then we might proceed on some definite plan. But no living man can always diagnose those intra-abdominal growths, and I think Tait[1] speaks the full truth when he says "that some of them will defy the most expert pathologist to recognize them, even when removed." Pozzi[2] tells us in his masterly work on gynæcological surgery, that fibroids of the uterus, regardless of their precise anatomical situation, may be treated in general by three methods:

1st. When there is no serious local complication, by electricity.

2d. By the artificial production of the menopause, by double castration or spaying.

3d. By the removal of the neoplasm, through active surgical interference, either through the vaginal passages, as practised by Péan, or through the hypogastric incision—the operator taking with the growth, through the incision, the uterus, tubes or ovaries, as may be required.

My patient would have nothing more to do with electricity, so that castration and excision remained. When the nature and scope of the operation—which had for its purpose removing the ovaries—were explained to her, she was averse to it, and demanded the removal of the growth—uterus and appendages if necessary. It was most providential that she did refuse oöphorectomy, for, as will be seen, the

[1] Tait, in discussion on Abdominal Surgery, before the London Medical Society in April, 1890.

[2] Pozzi, Traité Gynécologique Clinique et Opératoire, p. 973.

performance of that operation would have been almost impossible in this case, and have accomplished no good.

I now made a most thorough examination, with a view of exactly locating the growth and of determining, whether it was polypoid, pedunculated or sessile; intra, or extra uterine, single or double. In passing a sound, I found that it entered what seemed a narrow, sinuous track for a distance of nearly six inches. It seemed to pass through the centre of the mass, nearly as far up as the navel. On moving the growth externally it transmitted a movement to the handle of the sound in the deep vagina, so that it was evident, whatever it was, it had an extensive and intimate connection with the uterus.

On the 6th of November, with the assistance of Drs. Malcolm McLean, Ira B. Read, Geo. D. McGauran, Daniel J. Sheahan, James Moran and Thomas Stephenson, at the home of the patient, I proceeded to operate. Having fortified myself with ample assistance, a double relay of instruments, and hoping to encounter but few old adhesions, I hoped to cut rapidly and make a short operation.

Commencing with a long incision, which extended from the umbilical scar to the pubis, the peritonæum was soon reached. This was nicked wide enough, to admit the finger, on which, the scissors was passed, for its division, from end to end. As the lips of this membrane retracted, the convex surface of the large mass rolled into the gap. It presented a most singular sight. On its deep, crimson, glistening surface, running almost vertically from its base upward, lay convoluted in places a round, thick cord; in appearance and consistence it bore a most singular resemblance to the funis. This was the Fallopian tube. Over to the left of, but a little above the umbilicus, was an oblong roundish body about the size of a hen's egg. Large vascular channels, in the form of an extensive plexus, coursed over the entire surface of the growth.

It was evident that we had to deal with an interstitial fibroid, which had originated in the left cornu of the uterus, and by a slow concentric growth, gradually spreading into the submucous tissues; in time wholly encircled the uterine cavity, enlarging mainly on the left side—lifting up, and rolling over the fundus in such a manner, as to turn the uterus completely on its vertical axis.

As seen in the diagram, the left ovary lay on the summit of the tumor, while the Fallopian tube, on its uterine end, lies on the convex border, but as it lengthened out, assumed the outline of a circle, its fimbriæ in convenient proximity to the ovary.

The left ovary, which lay so high up and was dragged so far away from its normal position, had the feel of a cyst, and when punctured gave issue to a quantity of serous fluid; nevertheless, beneath its

capsule there yet remained a considerable fringe of the healthy stroma. In exploring for the right ovary, nothing could be discovered except a flat, small, oblong scar in the broad ligament—the remnant, no doubt, of an organ long since disorganized.

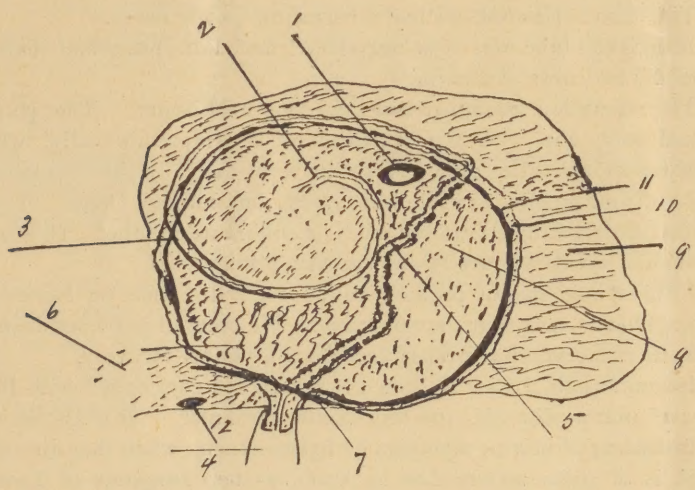

DIAGRAM SHOWING THE RELATION OF THE PARTS.

1. Left ovary displaced with central absorption.
2. Fimbriated terminus of left Fallopian tube.
3. Elongated and hypertrophied Fallopian tube, left.
4. Elongated vaginal cavity, drawn upward.
5. The long, tortoise-like remnant of the uterine cavity.
6. Right broad ligament.
7. Line of incision, just above the internal os.
8. Neoplastic growth.
9. Left broad ligament, anterior lamina.
10. Peritoneal tunic.
11. Cellular or subperitoneal coat.
12. Cicatricial remnant of right ovary.

In order to get at the base of the cervix, on the left side, the layers of the broad ligament had to be clamped off and divided.

Now, that a point was reached low down, corresponding with the internal os, a double-barred steel clamp was applied, and screwed up until it was apparent that the main vessels, were safely occluded.

An oval incision was then made across the anterior aspect of the growth, which was detached down to the vesico-vaginal septum. Another was made with the scalpel posteriorly, when the stub, or uterine body, was cut away with the scissors.

At this stage, the abdomen and pelvis were flushed with warm sterilized water and mopped dry. The uterine arteries were securely ligatured and the whole surface of the pedicle covered by the detached flaps of peritonæum. In fact, we treated the stalk, precisely as we do the stump of an amputated limb.

The clamp removed, we had a clean, dry pelvic basin.

A drainage-tube was now introduced and the abdominal incision closed by two rows of sutures.

The operation occupied one and one-half hours. The patient reacted well, and with the exception of a tympanitic belly, which threatened to spoil the case, everything went well. In this tympanites, castor-oil and magnesia citrate were given, but without effect. I then resorted to rectal injections and the long rubber rectal tube. This latter invaluable expedient gave immediate and lasting relief.

I visited my patient professionally for the last time on November 24th, eighteen days after the operation. We secured good solid union of the incision, and our woman has made a perfect recovery.

In conclusion, I wish to note a few points in connection with these cases of uterine fibroids, and this one in particular. It is known that the treatment of uterine myomata by hysterectomy, when they are interstitial, is of quite recent date in America—two surgeons of Lowell, Mass., Drs. Walter Burnham and John F. Kimball, being the first to venture the removal of the uterus through the abdominal incision. Burnham removed the uterus accidentally, not knowing that it was included in the mass until it was on the table. Kimball, however, performed his hysterectomy deliberately, and is therefore entitled to priority proper. It seems that both patients died, neither surviving forty-eight hours.

It is clear, in this case, that our line of procedure was the *ultima ratio*. Electricity was faithfully tried, and failed.

What would castration accomplish in this case?

Who would think of going up into the umbilical region for the ovary?

No good would have been derived from removing the right ovary, for the uterine end of the tube was impervious and the organ itself, had degenerated.

This long tortoise track—extending from the ostium internum to the farther extremity of the growth—is interesting to examine, as demonstrating how ovulation and the menstrual flux were maintained by the mere shell of ovular tissue, remaining.

The main controversy, in connection with the technique of hysterectomies, has been the management of the stump or pedicle: whether to depend on the searing-irons and cauterize; secure with the ligatures

and treat it intra-peritoneally, or bring the stump into the incision, and retain with the "black knot."

This fear of hæmorrhage is a well-grounded one, and we must leave nothing undone to provide against it. In the young or healthy middle-aged I would prefer to bury the pedicle; but with one suffering from constitutional disease or in advanced years, in whom atheroma of the arteries is expected, to securely guard against secondary hæmorrhage, I would prefer to have the mouths of the vessels within convenient reach.

No antiseptics were used in flushing, though the integuments were thoroughly purified and the instruments well boiled. Indeed, in the last six abdominal sections which I have performed, within the past two months' no antiseptics of any kind were employed within the peritonæum—four of those in the homes of the patients—and in no instance did septic invasion follow.

I do not believe it matters where an operation is performed, provided the hygienic surroundings are proper, the nursing, dieting and medical attendance up to the standard.